Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: (608) 266-2112

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

APPLICATION INFORMATION FORM

ATTENTION

IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 *working* days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925.** The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: http://www.drl.state.wi.us. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days *of receipt* of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: http://www.drl.state.wi.us. Look under "Business/Professional License Lookup" for your official credential number and grant date.

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MEDICAL EXAMINING BOARD

APPLICATION FOR TEMPORARY EDUCATIONAL PERMIT

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth _____ month _____ day _____ year

Daytime Telephone Number ( ) _____ - _____

Ethnic/gender status information is optional. **Sex:** ☐ M ☐ F **Ethnic:** ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____ **Location:** _____ (City, State/Country)

Date Diploma: _____ month/day/year **Degree:** _____ **Specialty:** _____

ACCOUNT FOR ALL ACTIVITIES FROM THE DATE OF GRADUATION FROM MEDICAL SCHOOL TO THE PRESENT TIME. MUST INCLUDE PROFESSIONAL AND NONPROFESSIONAL (PERSONAL) ACTIVITIES. ALL TIME MUST BE ACCOUNTED FOR. (Attach additional sheets if necessary)

INTERNSHIPS: HOSPITAL	**LOCATION City, State, & Country**	**BEGINNING DATE mo - yr**	**ENDING DATE mo - yr**
1.			
2.			

RESIDENCIES OR FELLOWSHIPS: (Attach additional sheets if necessary)

NAME OF HOSPITAL OR CLINIC	**LOCATION** (City, State & Country)	**DATES (from - to) mo - yr**
1.		
2.		
PRACTICE	**LOCATION** (City, State & Country)	**DATES (from - to) mo - yr**
1.		
2.		

APPLICATION MUST BE ACCOMPANIED BY:

1. Fee - $10.00
2. Copy of professional diploma & official translation if necessary.

For Receipting Use Only

#564 (Rev. 4/03)
Ch. 448, Stats.

State of Wisconsin Department of Regulation & Licensing

ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED
_____ YES _____ NO	_____ YES _____ NO	_____	_____

		YES	NO
1.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
2.	Have you ever failed to pass any state medical board examination, national board examination, USMLE, or FLEX examination? If yes, give details on an attached sheet.	☐	☐
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
5.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
6.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
7.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and, if applicable, list name, address and phone number of your probation or parole officer.	☐	☐
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
9.	Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	☐	☐
10.	Are you registered, certified or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	☐	☐
11.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐
12.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

For the purposes of questions 12-18 n, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
13.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
14.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	☐	☐
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	☐	☐
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	☐	☐
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐	☐
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	☐	☐

AFFIDAVIT OF APPLICANT
(Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

SEAL

_____
Date Commission Expires

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____ month _____ day _____ year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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PHYSICIAN TEMPORARY EDUCATIONAL PERMIT

AFFIDAVIT OF HOSPITAL AUTHORITY

TO BE COMPLETED BY THE ADMINISTRATOR OF THE HOSPITAL ONLY IF THE PHYSICIAN IS ENROLLED IN AN AMA OR AOA APPROVED RESIDENCY PROGRAM ACCREDITED BY ACGME IN THE STATE OF WISCONSIN.

_____ , _____
(Name) (Address)

a graduate of the _____ Medical School,
(Name of School)

_____ , has made application for post-graduate training in this
(Address of School)

hospital, the _____
(Name of Hospital)

_____ under the provision of a Temporary Educational Permit,
(Address of Hospital)

Permit, which will entitle him/her to receive training under our supervision for a period not to exceed one year, with renewals at the discretion of the Medical Examining Board not to exceed four additional years, upon recommendation of the administrator of this hospital.

We have examined the credentials of Doctor _____ and find that they meet the requirements of the Medical Examining Board regulations governing these permits, and are satisfactory to this Hospital. I hereby recommend that the board consider the application of Doctor _____ for a Temporary Education Permit, with his/her post-graduate training to begin in this hospital on _____, 20_____.

_____ _____
Signature of Administrator Name of Hospital

_____ _____
Print Name Address of Hospital

_____ ***HOSPITAL SEAL***
Date

#2601 (3/03)

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

month _____ day _____ year _____

Social Security Number

_____

Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include <u>all</u> convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	**DATE**	**CITY/STATE**

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

		YES	NO	MO/YR COMPLETED
3.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
	Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

		(Check all that apply)	YES	NO	MO/YR COMPLETED
4.	Have you ever been sentenced to:	☐ Probation	☐	☐	_____
		☐ Parole	☐	☐	_____
		☐ Ordered to pay restitution	☐	☐	_____
	Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____ _____

Signature Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/19/02) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code

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APPLICATION PACKET ADDENDUM (INTERNET)

MD and DO Temporary Educational Permit application packet

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

_____ _____
Full Name Daytime Phone Number

_____
Street Address

_____
PO Box

_____
City, State, Zip

Thank you.

#2612 (4/03)